DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 1 — 0 0 6

2. STATE: Pennsylvania

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) Title XIX

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.250

7. FEDERAL BUDGET IMPACT:
a. FFY 01 $956,167
b. FFY 02 $5,829,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
4.19D Part 1
Pages 3, 3a, 6, 7, 7a, 8, 9, 13, 14, 15, 16

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
4.19D Part 1
Pages 3, 6, 7, 7a, 8, 9, 13, 14, 15, 16

10. SUBJECT OF AMENDMENT:
Change to the methods and standards for setting payment rates for nursing facility services relating to movable property.

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Review and approval authority has been delegated to the Secretary of Public Welfare

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Feather O. Houstoun

14. TITLE:
Secretary of Public Welfare

15. DATE SUBMITTED: 9/20/01

16. RETURN TO:
Commonwealth of Pennsylvania
Department of Public Welfare
P.O. Box 2675
Harrisburg, PA 17102

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: JUN 17 2002

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 7/1/01

20. SIGNATURE OF REGIONAL OFFICIAL:
Claudette V. Campbell

21. TYPED NAME:
CLAUDETTE V. CAMPBELL

22. TITLE: ASSOCIATE REGIONAL ADMINISTRATOR
DIVISION OF MEDICAID & STATE OPERATIONS

23. REMARKS:

reported costs, as adjusted to conform to Department regulations, for that unaudited cost report period until the audit has been completed.

d. Transition

For net operating prices effective on or after July 1, 2001, the Department will revise the audited costs of cost reports in the NIS database for fiscal periods beginning prior to January 1, 2001 by disregarding audit adjustments disallowing or reclassifying to capital costs, the costs of minor movable property (as defined in § 1187.2, effective on July 1, 2001) or linens reported as net operating costs. The Department will not adjust the audited statistics when revising the nursing facility audited Resident Care, Other Resident Care and Administrative allowable costs to disregard the audit adjustments relating to minor movable property and linen costs. After revising the audited costs to disregard these adjustments, the Department will recalculate the maximum allowable administrative cost, and will disallow administrative costs in excess of the 12% limitation as specified in § 1187.56(1)(i).

e. Inflation Factor

The Department trends the cost in the database forward to the midpoint of the year for which the prices are being set using the most current available HCFA Nursing Home without Capital Market Basket Index, total index level, at the time price setting calculations are done.

2. Peer Grouping

After the Department selects the database for the price setting period, the Department classifies each participating nursing facility into one of 14 peer groups for net operating price setting. The Department classifies facilities that meet the Department's definition of hospital-based nursing facility and special rehabilitation facility into two separate statewide peer groups. To establish the twelve remaining peer groups, the Department uses the most recent MSA group classification, as published by the Federal Office of Management and Budget on or before April 1 of each price setting period, to classify each nursing facility into one of three MSA groups or one non-MSA group. The Department then uses the bed size of the nursing facility on the final day of the reporting period of the most recent audited MA-11 cost report in the NIS database to classify the nursing facilities into one of three bed size groups. These groups are 3 - 119 beds; 120 - 269 beds; and 270 beds and over. Except for the hospital-based nursing facility and the special rehabilitation

facility peer groups, the Department will collapse a peer group with fewer than seven nursing facilities into the adjacent peer group with the same bed size. If there are two adjacent peer groups with which to merge, the peer group with fewer than seven nursing facilities will be collapsed into the peer group with the larger population MSA group.

3. Peer Group Price and Net Operating Rate Setting

Once the Department classifies nursing facilities into the appropriate peer groups, the Department then calculates the prices for each peer group. Under the case-mix payment system, nursing facility net operating costs are separated into three cost centers: resident care cost center, other resident related cost center and administrative cost center. The Department sets prices for each cost center and peer group on an

occupancy. The Department then divides the audited allowable administrative costs for each cost report for each nursing facility by the total audited actual resident days, adjusted to 90% occupancy, if applicable, for each cost report year to obtain each nursing facility's administrative cost per diem for the cost report year.

For year two of implementation, the Department calculates the two-year arithmetic mean of the administrative cost for each nursing facility to obtain the average administrative cost per diem of each nursing facility.

For all subsequent years, the Department calculates the three-year arithmetic mean of the administrative cost for each nursing facility to obtain the average administrative cost per diem of each nursing facility.

The Department arrays the average administrative cost per diem for each nursing facility within the respective peer groups to determine a median for each peer group. The Department multiplies each median by a factor of 1.04 to determine the price for the peer group. The Department assigns that price to each nursing facility in the peer group.

A nursing facility's administrative rate equals its administrative peer group price.

d. Net Operating Rate

The Department determines each nursing facility's per diem net operating rate by adding the nursing facility's case-mix adjusted resident care rate, its other resident related rate and its administrative rate.

4. Capital Rate Setting

The facility-specific capital rate consists of three components: the fixed property component, the movable property component, and the real estate tax component.

(a) Fixed Property Component

The nursing facility's fixed property component is based on the depreciated replacement cost of the nursing facility's fixed property and the associated financial yield rate.

On an annual basis, the Department determines the depreciated replacement cost of each nursing facility's fixed property as of March 31, and uses that determination in setting the fixed property component for the rate year beginning on the following July 1.

The Department determines the depreciated replacement cost of the nursing facility's fixed property based on the most recent initial appraisal, reappraisal or updated appraisal, as modified by any limited appraisals, as of March 31. Reappraisals will be completed at least every five years. Limited appraisals will be conducted when a nursing facility makes additions or deletions to fixed property of more than $200,000 or 10% of the appraisal value, whichever is lower.

The Department adjusts the appraised depreciated replacement cost of the nursing facility's fixed property to account for the per bed limitation set forth at § 1187.112 (relating to cost per bed limitation adjustment) and the capital component payment limitation addressed in § 1187.113 (relating to capital component payment limitation).

The Department multiplies the adjusted depreciated replacement cost of the fixed property by the financial yield rate to determine the fair rental value for the nursing facility's fixed property.

The nursing facility's fixed property component equals the fair rental value of its fixed property.

When there is a change in nursing facility ownership, the new nursing facility owner is deemed to have the same appraised depreciated replacement cost as the former owner.

(b) Movable Property Component

When the nursing facility's most recent audited MA-11 cost report available in the NIS database for rate setting is for a cost report period beginning prior to January 1, 2001, the Department bases the movable property component of each nursing facility's capital rate on the depreciated replacement cost of the nursing facility's major and minor movable property and the associated financial yield rate.

On an annual basis, the Department determines the depreciated replacement cost of each nursing facility's movable property as of March 31, and uses that determination in setting the movable property component for the rate year beginning on the following July 1.

The Department bases the determination of the depreciated replacement cost of each nursing facility's movable property on a movable property appraisal.

The Department multiplies the depreciated replacement cost of the movable property by the financial yield rate to determine the fair rental value for the nursing facility's movable property.

The nursing facility's movable property component equals the fair rental value of its movable property.

When there is a change in nursing facility ownership, the new nursing facility owner is deemed to have the same appraised depreciated replacement cost as the former owner.

When the nursing facility's most recent audited MA-11 cost report available in the NIS database for rate setting is for a cost report period beginning on or after January 1, 2001, the Department bases the amount of the movable property component on the audited actual acquisition costs of major movable property as set forth in the most recent audited MA-11 cost report available in the NIS database.

(c) Real Estate Tax Cost Component

The Department determines the real estate tax cost component of each nursing facility's capital rate based on the audited actual real estate tax cost, as set forth on the most recent audited MA-11 cost report available in the NIS database.

(d) Capital Rates

The Department adds the nursing facility's fixed property component, movable property component and real estate tax component and divides the sum of the three components by the nursing facility's total actual resident days, adjusted to 90% occupancy, if applicable.

The Department makes capital component payments for fixed property for nursing facility beds constructed, licensed or certified after November 29, 1997, if the Department approves those beds as replacement beds in accordance with Chapter 1187, § 1187.113a(c)-(e).

The Department grants waivers of § 1187.113(a) to permit capital cost reimbursement for fixed property as the Department in its sole discretion determines necessary and appropriate. The criteria the Department uses to evaluate and approve applications for capital cost reimbursement waivers are contained in § 1187.113(b). Waivers of the moratorium regulations granted to nursing facilities under 55 Pa. Code Chapter 1181 remain valid, subject to the same terms and conditions under which they were granted, under the successor regulations set forth at 55 Pa. Code § 1187.113(a). Waivers of § 1187.113(a) will not otherwise be granted except as provided under § 1187.113(b).

5. Case-Mix Per Diem Rate

A nursing facility's case-mix per diem rate for an MA resident day is the sum of the nursing facility's net operating rate and its capital rate. The Department calculates payment rates on a quarterly basis. Rates are set for nursing facilities with a change of ownership, new nursing facilities and reorganized nursing facilities as specified in § 1187.97 (relating to rates for new nursing facilities, nursing facilities with a change of ownership, reorganized nursing facilities and former prospective payment nursing facilities) of the state regulations.

C. Cost Finding

All nursing facilities participating in the Medical Assistance Program shall use the direct allocation method of cost finding. Under this method of cost finding, costs are apportioned directly to the nursing facility and residential or other facility based on the appropriate financial and statistical data.

D. Cost Reporting and Audit Requirements

All nursing facilities participating in the MA Program shall report allowable costs and the results of the cost finding process on forms specified by the Department. Allowable costs are classified in four cost centers: resident care; other resident related; administrative and capital. Net operating costs include resident care, other resident related and administrative. All records are subject to verification and audit. The financial and statistical records of all nursing facilities are audited periodically by either the Department or the Auditor General.

A nursing facility shall hold, safeguard and account for residents' personal funds upon written authorization from the resident in accordance with all applicable provisions of state and federal law. The Department periodically audits residents' personal fund accounts.

E. Allowable Program Costs and Policies

Allowable costs are those costs which are necessary and reasonable for an efficiently and economically operated nursing facility to provide services to MA residents. Allowable costs are identified in and subject to limitations specified in Subchapter E (relating to Allowable Program Costs and Policies), Subchapter F (relating to Cost Reporting and Audit Requirement) and Subchapter H (relating to Payment Conditions, Limitations and Adjustments) of 55 Pa. Code Chapter 1187, including the related party cost and prudent buyer principles set forth in Sections 1187.57 and 1187.60. Only the direct and indirect costs related to resident care are allowable. Any costs of materials or services covered by payments made directly to providers, other than nursing facility services under Medicaid and Medicare or other insurers and third parties, are not allowable.

All nursing facilities participating in the MA Program must allocate costs between nursing facility services and non-nursing facility services in accordance with the allocation bases established or approved by the Department.

F. Hospice Services

If an MA recipient residing in a nursing facility is dually eligible for Medicare Part A services and elects to receive hospice services in lieu of nursing facility services, as applicable, the MA Program pays a Medicare-certified hospice provider an amount equal to the room and board payment made to the nursing facility as part of the nursing facility services and will discontinue direct payment to the nursing facility for services. The hospice provider, in order to receive payment from the Department, shall enter into an agreement with the nursing facility by which the hospice provider agrees to assume full responsibility for the recipient's hospice care and the nursing facility agrees to provide room and board to the recipient. (See Attachment 4.19B, Item #21)

2. The Department will identify eligible county nursing facilities.

3. The Department will negotiate a total supplementation payment amount with eligible county nursing facilities. The negotiated total supplementation payment amount may equal but will not exceed the Medicare upper limit amount calculated in step 1 above.

4. The Department will select the latest fiscal period for which all eligible county nursing facilities have an acceptable cost report on file with the Department and will sum the total MA allowable costs reported by the eligible county nursing facilities for that fiscal period.

5. The Department will divide the total supplementation payment amount by the total MA costs to derive the supplementation percentage.

6. The Department will multiply each eligible county nursing facility's reported MA costs for the fiscal period selected in step 4 above by the supplementation percentage to determine that county nursing facility's supplementation payment.

J. Exceptional Payments

1. Exceptional Payment Agreements Prior to January 1, 1996

Prior to January 1, 1996, the Department entered into exceptional payment agreements to provide additional payments for certain services/supplies which included ventilator rental equipment, supplies necessary because of ventilator dependency, respiratory hours, additional nursing hours and intensive head injury programs with extensive physical, speech and occupational therapy to high technology-dependent residents, such as ventilator dependent and head and/or spinal cord injured individuals. The Department will continue to make payment under exceptional payment agreements for residents who were receiving services/supplies under this program prior to the implementation of the case-mix payment system on January 1, 1996 until these services/supplies are no longer needed or desired by the resident; upon 30 day written notice to the nursing facility; or upon the nursing facility's breach of the agreement.

2. Exceptional Payments During the Period January 1, 1996 through October 31, 1999.

Beginning on January 1, 1996, the Department began entering into Exceptional Payment Agreements in accordance with the following provisions: With the implementation of the case-mix payment system, in limited instances, the Department entered into exceptional payment agreements with participating nursing facilities to make payments in addition to the nursing facilities' case-mix per diem rate for high technology-dependent residents, such as ventilator dependent and head and/or spinal cord injured individuals. To receive exceptional payments for a high technology-dependent resident, a nursing facility had to demonstrate to the satisfaction of the Department that its case-mix per diem rate did not cover the additional exceptional costs that the nursing facility incurred to care for the resident.

If the Department was satisfied that the nursing facility's case-mix per diem rate did not cover the additional exceptional costs related to the care of the high technology-dependent resident and that the resident could not otherwise obtain appropriate care, the Department could enter into an exceptional payment agreement to pay for additional costs necessary for the care of the exceptional resident. These additional costs were limited to: the rental of equipment and the supplies necessary to care for high technology-dependent residents.

The Department entered into an individual exceptional payment agreement for each exceptional resident and negotiated with the nursing facility the additional costs to be paid thereunder on a case-by-case basis.

The Department does periodic physician assessments of each exceptional resident to determine what the resident's current special medical needs are and how these needs can be met.

To receive payments for an exceptional resident, the nursing facility bills its case-mix rate for the resident. The nursing facility also submits a separate invoice each month for items specified in the exceptional payment agreement. The nursing facility must attach documentation to the monthly invoice verifying what special services/supplies were actually received by the resident for the month. The Department reviews the documentation and authorizes payment with the exceptional payment agreement only for services/supplies received by the resident for the applicable month and covered under the exceptional payment agreement.

During the audit, the Department ensures that the nursing facility adjusts its reported costs on the cost report to account for the exceptional reimbursement. Payment by the Department of the rates permitted by the exceptional payment agreement shall be payment in full for additional nursing facility services/supplies (above the customary MA covered services) required and received by the specified resident.

The Department will continue to make payments under exceptional payment agreements entered into during the period January 1, 1996, through October 31, 1999, in accordance with and subject to the terms and conditions in those agreements.

3. Exceptional Payments on or after November 1, 1999.

Beginning November 1, 1999, in addition to payments based upon the nursing facility's case-mix per diem rate the Department will issue exceptional Durable Medical Equipment (DME) grants that authorize payments for certain exceptional nursing facility services involving the purchase or rental of exceptional DME. For purposes of these grants, exceptional DME must have a minimum acquisition cost that is equal to or greater than an amount specified by the Department and is either specially adapted DME or such other DME that is designated as exceptional DME by the Department. The Department will identify the minimum exceptional DME acquisition cost and other designated exceptional DME annually by notice in the Pennsylvania Bulletin.

To receive an exceptional DME grant for a resident, a nursing facility must submit a request on forms designated by the Department. The Department will issue an exceptional DME grant if the Department determines that: (1) the nursing facility's request complies with all applicable Department instructions; (2) the DME specified in the nursing facility's request is medically necessary; (3) the DME specified in the nursing facility's request is exceptional DME; (4) the nursing facility's physical plant, equipment, staff, program and policies are sufficient to insure the safe, appropriate and effective use of the exceptional DME; (5) the nursing facility has exhausted all third party medical resources, and; (6) during the period November 1, 1999 through June 30, 2001, the nursing facility has executed a written grant agreement on a form designated by the Department or, effective July 1, 2001 and thereafter, the facility certified to the Department in writing, on a form designated by the Department, that it has read and understands the terms of the grant.

When the Department issues an exceptional DME grant to a nursing facility, the Department identifies the resident to whom the exceptional services are being provided, the specific equipment and related services paid by the exceptional DME grant, the amount of the exceptional payment(s), and the terms and conditions under which the payment(s) will be made. An exceptional DME grant is effective on the date specified in the nursing facility's grant and ends on the date the exceptional DME grant is terminated pursuant to § 1187.156 (relating to termination or suspension of exceptional DME grants and recovery of exceptional payments).

The maximum allowable exceptional payment authorized by an exceptional DME grant is limited to the lowest of the following: (1) The lower of the nursing facility's costs to obtain the exceptional DME and related services and items; or, in the event the nursing facility is obtaining the exceptional DME or related services and items from a related party as defined in 55 Pa. Code § 1187.2 (relating to definitions), the related party's cost to furnish the exceptional DME and related services and items to the nursing facility; (2) The applicable MA outpatient fee schedule amount, if any; or, (3) Eighty percent (80%) of the amount, if any, that would be approved by Medicare if the DME or service or item were a Medicare Part B covered service or item.

The amount of the exceptional payment(s) authorized by the exceptional DME grant are deemed to be the necessary, reasonable and prudent costs of the exceptional DME and the related services and items identified in the nursing facility's exceptional DME grant.

The exceptional payment is paid in either lump sum or monthly payments depending on which method is in the best interest of the MA program. Authorization for monthly payments continues during the term of the nursing facility's grant except during a period of suspension as specified in § 1187.156 (relating to termination or suspension of exceptional DME grants and recovery of exceptional payments).

All nursing facility services provided by a nursing facility receiving an exceptional DME grant, including services paid by the grant, remain subject to applicable federal and state laws and regulations, including the laws and regulations governing the MA Program.

Nursing facility services paid by an exceptional DME grant are subject to review by the Department to ensure compliance with the terms and conditions of the exceptional DME grant. The Department will perform periodic assessments of each resident receiving nursing facility services paid by an exceptional DME grant to determine the continuing need for the exceptional DME.